IL-MUSBIEH

MALTA NURSING AND MIDWIFERY JOURNAL

Malta Union of Midwives and Nurses

No.64 - Settembru 2014

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Settembru 2014

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editorial

Dementia patients in our hospitals

It is encouraging that we have a National Dementia Strategy for Malta 2015-2023 and free dementia drugs for all those afflicted which count almost 5000. The problem is that in 30 years time we will have 14,000 patients afflicted with this condition. Knowledge and training in dementia care is often neglected especially in our general hospitals and our ward environment is not dementia-friendly.

Nurses and other caregivers are facing massive increases of patients with mental health problems in our general hospitals and most of them have dementia. Our Nurses have a lot of experiences of caring for dementia patients but they also struggle daily with the problems these patients create at ward level. The scenario of a 'disruptive' dementia patient and nurses juggling through their shifts in very busy setups must be always kept in mind.

Wanderers are a headache. They most probably wander off in very awkward hours of the day, remove their identification bracelet, 'pack up' their 'belongings' and disappear somewhere with their hospital or casual attire. This causes a lot of stress to our caregivers and charge nurses. Time is lost running after patients, phoning firms and administration, contacting relatives and police, trying to get help from hospital securities, and being asked to do incident reports. The perception is, even from the medical profession that our patients cannot just 'run away'. In fact, yes, they do, because our wards are not designed to prevent this.

Other problems that caring staff suffer with regards dementia patients are violence: physical and verbal. Most of the time patients are also restless, confused and very vocal. This is not the patient's fault, but it's just a fact. That is why restraint measures are sometimes applied by nurses, but this is often misunderstood by the patient's firm or their relatives. Another problem is that there are no hospital guidance on how to deal with a confused or forgetful older patient. The focus is, many a times, the care of chronic disease management – asthma, diabetes, heart disease but not dementia. Half of all dementia patients treated in hospital end up in a worse state. In fact dementia care must be given priority too, like any other hospital service and treatment. Half of the dementia patients' health worsens partly as they spend much longer in hospital after a fall, hip replacement, infection or stroke than other patients. This has nothing to do with care; this has to do with the change of environment and the stress of the illness or injury themselves.

Nurses and caregivers have to be educated and updated continuously on the subject of dementia especially with regards detecting early signs of dementia, dealing with dementia and confusion. Mandatory training for hospital nurses includes hand washing and infection control but not how to deal with the problem behaviours that patients with dementia can exhibit. We are left to deal with difficult behaviour as best we can.

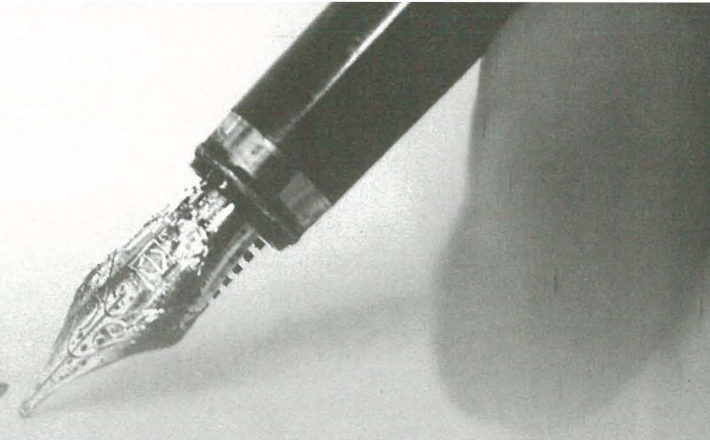
Social and behavioural problems in dementia are often overlooked. The National Dementia Strategy aims to improve public and professional awareness, which we fully support whilst half of all dementia patients treated in hospital end up in a worse state. Care plans for very confused patient on an acute medical ward and one-to-one nursing are important measures for the care of such patients but most often they are not implemented.

One final question: Are our wards in general hospitals, dementia-friendly? Probably not! This is why our wanderers wander off. There is no tool in our hospital to measure dementia-friendliness. Our wards do not offer meaningful interaction between patients, their families and staff. Our hospitals do not offer activity centres similar to geriatric residences. Hospital environment does not promote well-being, self-care and mobility. Our wards are not supplied with 'tracking devices' and do not promote orientation, calmness and security neither. Security in fact, is the biggest concern. Another problem is funding: Why has the National dementia expenditure been reduced to 50% in the 2014 budget?

Our Hospital Management and Health Authorities have to prove they are dedicated dementia champions to deliver optimum dementia care and philosophy of well-being.

Editor

President's message



The timing of this article coincides with the deployment of the newly graduates which should take part sometime during this month of September. MUMN has reached an agreement that all newly graduates will have an induction course during their first weeks when they are deployed in the clinical settings. Such induction course is essential since no transient period for such students exists.

MUMN has made its own enquires to update the vacancies available, the new services being planned to start functioning in the next ten months and to take into account the number of nurses who are about to retire during the same period.

When taking a snap shot of all entities, a staggering figure emerged on the number of nurses needed in every hospital, elderly set ups and the health centres. More than 600 nurses are needed to fill the existing vacancies and the new services being planned to start in the next ten months. 600 nurses are needed when the intake into the nursing work force will be just over 200, including the Spanish nurses which were promised by the Health Division to arrive later on this year.

As one can see, the persistent problem of shortage of Nurses and Midwives continues to plague our hospitals, especially when new services are being planned to commence, without allowing existing vacancies to be filled. Not to mention also that all hospitals and health centres need a sizable number of nurses to be organized into a relieving pool to compensate any vacation leave and sick leave which may arise on a day to day basis.

MUMN would be stressing with the authorities concerned that the vacancies in the clinical areas should be given a top priority and that all hospitals should have their vacancies addressed.

The shortage of beds is still plaguing Mater Dei Hospital. The strategy to continue buying beds for the elderly in the private sector was used by the previous and present political administration. This, in the eyes of MUMN, is just a short term solution since we are not addressing the main issues which include the work practises in MDH and the Primary Health Care services.

Health centres are both essential and also offering a sterling service to the community, but, it is not the building of further health centres which is needed, but like what other European Countries have been adopting, that is, by going into the homes of those in need and offering them all the necessary personnel, care and providing them with services needed in their homes. Through this supportive and holistic way of practise in the community, early hospital discharge can be done and more hospital beds are made available.

MUMN has been stating this concept for the last ten years, when even presented a document on the 'Family Health Nurse', which such document was not even discussed by the Health Division. In the meantime MUMN listens to both the current Parliamentary Secretary and Shadow Minister expressing their vision on the GP as being the driving force in the Primary Care! Such vision is handicapped by its conception and will allow the current problems to prevail....so MDH and the huge waiting list to residential homes will continue to increase and flourish.

MUMN is appealing to all its members to update their existing information in the Union's Data Base. It is important that all those who have done any changes in their work places or status to kindly phone MUMN office on 2144 8542 or send us an email on administrator@mumn.org with the relevant information.

Paul Pace, President

Press Release - Friday 12th September 2014

Newly graduate midwives not recruited, while pregnant women and their babies lack midwifery services

MUMN criticise the Department of Health for not recruiting the midwives, and thus ensuring that the midwifery Department will have a compliment of midwives. The recruitment of these midwives is essential so that the maternity department provide high quality and safe care to pregnant women and their babies.

It is a pity that midwives are treated as a second class professionals, since nurses were recruited and employed on temporary appointment while midwives were left to register for work. MUMN find this unacceptable as MUMN officials had continuous correspondence with Hon. Mr. Chris Fearne, Parliamentary Secretary for Health, affirming the urgent need to recruit midwives.

MUMN thus appeal to all those responsible to ensure that these midwives are recruited like their nursing counterparts. If these midwives are not employed by Wednesday, 17th September 2014, MUMN will register an industrial dispute.

Maria Cutajar, Vice-President

Female Genital Mutilation

The Challenges It Brings

by Maria Cutajar, MUMN Vice-President (continued from last edition)

1. Identify and Tackle communication barriers:

Where possible, a migrant woman or girl in a healthcare setting should be provided with an interpreter, preferably female, in order to overcome any language barriers to communication. The health professional should not accept friends' or family members' offers to interpret on behalf of the woman/girl, to avoid the risk of emotional constraints, pressure on the patient or incorrect (subjective) interpretations of the patient's statements. Counselling should be carried out in a place (room) where the woman/girl's privacy and safety are ensured, and where nobody can enter without permission. All encounters should be confidential, respectful and mindful of the woman's/girl's dignity. In accordance with the customs of their cultures, many women may only be comfortable discussing this issue with another woman. They may have vivid, traumatic memories surrounding the event. Privacy and discretion should be strictly adhered to, and proper informed consent obtained before examination.

2. Be Sensitive and Non-Judgemental:

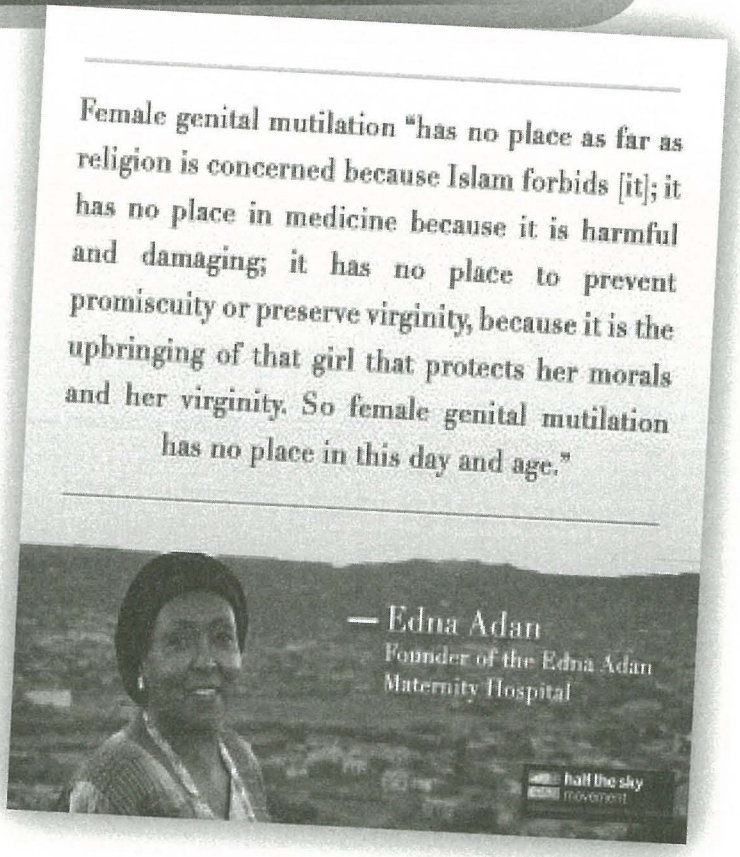
It is important to be non-judgemental about a woman's cultural beliefs, irrespective of one's own culture. Although FGM is a human rights violation, in the societies in which it is practised, it may be viewed as a compulsory procedure. Healthcare professionals need to be conscious of the political and cultural sensitivities surrounding this subject and, in particular, the term 'FGM'. When discussing FGM, other terms such as cut, closed or circumcised could be used in order to ease the flow of conversation. This will in turn make it easier for the girl/woman to open up and volunteer further information relating to her own case. Healthcare professionals need to be as general as possible in discussions with a client from a community that practises FGM, in order to avoid the girl/woman feeling targeted or stigmatised.

3. Children and FGM:

Healthcare professionals have a responsibility to protect children from FGM. Many women who have undergone FGM may have left their home countries to protect their own daughters from the practice. However, other women and their families having left their home countries may still support FGM. In such cases, healthcare professionals need to be aware of child protection issues and the rights of any girl children in these families.

4. Obstetric, Gynaecological and Health Issues:

Complications may occur with all types of FGM, but



risks can be higher with more extensive types of FGM. FGM Type III causes a direct mechanical barrier during a normal vaginal delivery. FGM Types I, II and IV can present with unintentional vulval and vaginal scarring and adhesion, narrowing and obliteration of the vaginal opening. Inadequate assessment may physically compromise mother and foetus.

Deinfibulation Procedure

When a woman with FGM Type III seeks antenatal care services, it is necessary to provide her with appropriate information regarding deinfibulation. Deinfibulation procedures can be carried out during pregnancy, intrapartum, at delivery, or at any other time upon request of the woman request or due to a health problem. The deinfibulation procedure should only be performed after consultation with the woman. The partner's/husband's involvement is important in the counselling process (together or in separate sessions).

Management of Antenatal Care

The antenatal period is the optimum time to identify a woman who has undergone FGM. During this time, counselling by skilled practitioners should take place with the woman and/or her partner (if she so wishes) regarding

the best management to achieve a safe delivery and prevent future FGM (to her or her baby). The woman and her partner should be advised about the consequences of FGM, propose a birth plan, and plan possible deinfibulation procedure (in cases of FGM Type III) (ideally pregnant women with FGM Type III should undergo deinfibulation between 20 and 28 weeks, allowing the area to completely heal well before delivery). Developing a rapport between the obstetrical team and the woman is vital. Scheduling frequent antenatal visits allows the woman to become more familiar and open to the team in the process of making decisions regarding her care. Recurrent urinary tract infections (UTIs) during pregnancy are a known risk factor for preterm labour and sepsis. It is important to be vigilant in screening women with FGM for recurrent urinary tract infections, as they are at particular risk.

Intrapartum Care/Women Presenting In Early Labour

A good rapport between the health care professionals and the couple need to be established. The couple should be approached in a sensitive, sympathetic, non-judgemental manner. If language is a barrier, an interpreter (ideally an unrelated, female interpreter) needs to be present, to avoid any miscommunication. Where possible seek to involve the woman's partner, and explain FGM, its complications and reversibility by drawing diagrams or using anatomical models.

When the introitus is aberrantly closed, such as in FGM Type III, it can be difficult to assess cervical dilation. The scar can be opened anteriorly (by a Doctor), and there is little bleeding from relatively avascular scar tissue. The incision should begin at the vaginal opening, extend anteriorly in the midline, and not extend beyond the urethra, as it may cause excessive bleeding due to the rich blood supply in the clitoral region. The edges of anterior incision should be sutured after labour (leaving the introitus open), unless suturing beforehand is needed to control excessive bleeding. **Do not reinfibulate:** in accordance with WHO guidelines, reinfibulation of the vulval area (for example in cases of FGM Type III) should not be performed in any circumstances. Several European countries prohibit the practice of FGM, although precise legal positions vary.

There can be prolonged second stage of labour because the vagina, perineum and the labia have all undergone mutilation that has left extensive scar formation, the vaginal canal becomes inelastic and the pelvic floor muscles rigid. This will prevent the normal and gradual dilation of the vagina as well as the descent of the presenting part of the child during the second stage of labour. Such a situation can lead to fetal and maternal complications.

Fetal and maternal complications:

Fetal complications	Maternal complications
Large caput formation	Obstructed labour
Excessive molding of the head	Extensive vaginal and perineal lacerations
Intra-cranial haemorrhage	Maternal distress
Hypoxia	Uterine inertia
Foetal distress	Uterine rupture
Intrauterine death	Impacted foetus
	Maternal death

Post-Natal Care

The mother/woman with FGM requires more than a routine postnatal visit - therefore extra time for the post-natal follow-up is needed. This is because, women with type III FGM need the same kind of postnatal care as other women, as well as additional information, counselling and support to help them adapt to changes following deinfibulation (if this was carried out), and to discourage them from seeking re-closure after discharge from the health unit. Counselling should focus on emotional and physical changes post-deinfibulation, which the woman is likely never to have experienced before:

Feeling of wetness;

Increased sensitivity in the vulva (due to being open - advise loose underwear to reduce discomfort caused by friction);

Urine and menstrual flow will appear heavier because of the removal of the scar tissue.

Specific needs of women with FGM must be addressed in a sensitive and compassionate manner, with an emphasis on good postnatal hygiene. In addition, couples should be advised to avoid intercourse until healing has occurred and to use a lubricant if necessary.

It is also important to provide separate psychosexual counselling to the husband, to make him aware of the importance of not closing the opened up infibulations. This should include clear information regarding the physical, psychological and legal implications of doing so. The husband and other family members who are influential in decisions about FGM (e.g. mothers and mothers-in-law) should also be counselled, with specific and clear information regarding the health and legal consequences of FGM. Extensive counselling may be required for women and their partners in order to understand the associated risks of reinfibulation, such as:

- Retention of lochia and sepsis
- Urinary tract infection and sepsis
- Poor healing, haemorrhage and infection
- Future obstetrical complications

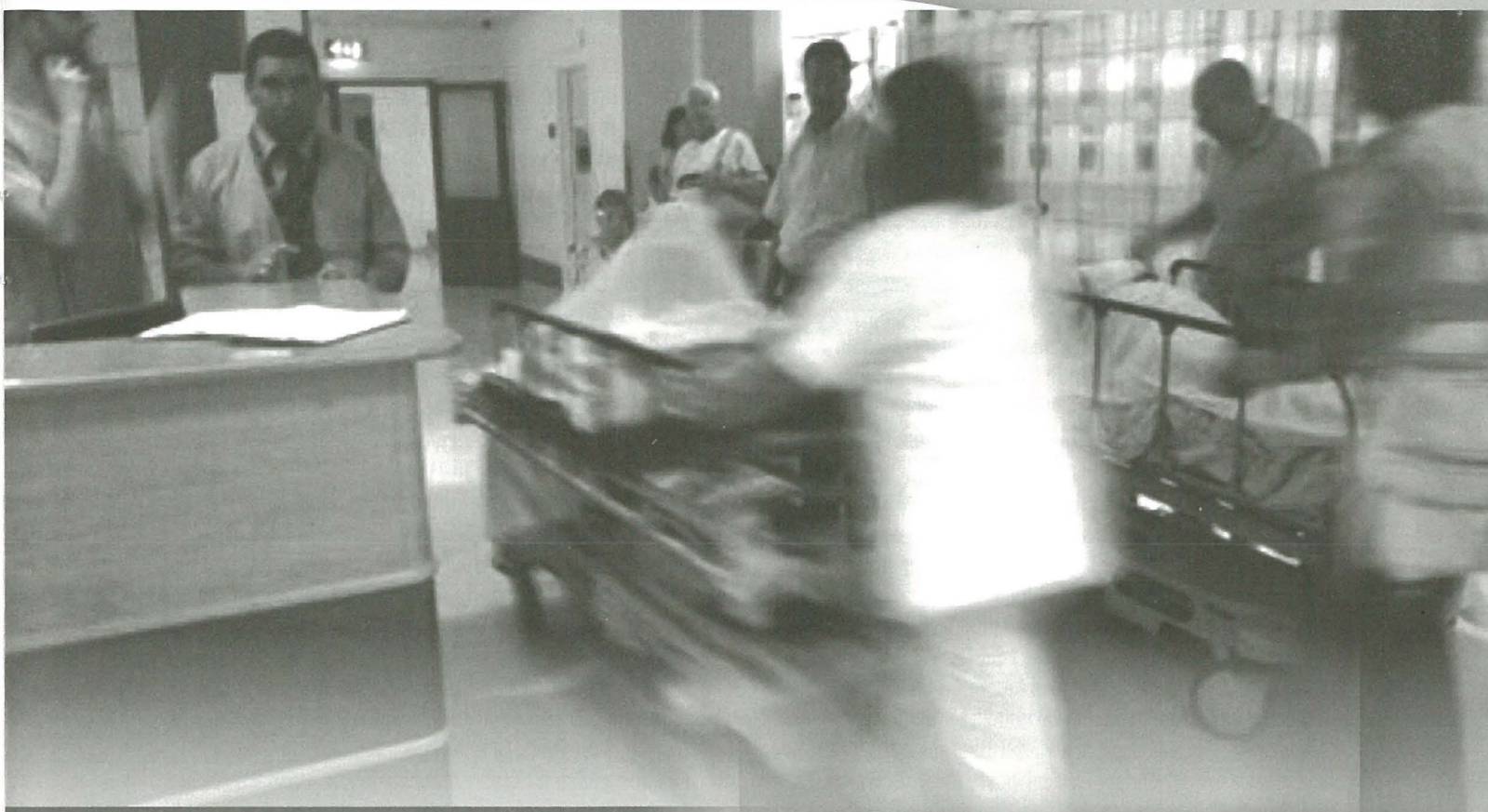
Female Genital Mutilation

continued from page 7

If the baby is a girl, counselling should also address risks regarding FGM and the child. Women with any type of FGM who deliver a baby girl should be counselled about the consequences of allowing her daughter to be excised. Where national legislation banning FGM does not exist, health professionals must nonetheless seek to advice and support at-risk women and girls and their families, in an effort to prevent the practice. The detrimental physical and psychological effects of FGM should be clearly described. European and international guidelines on the human rights issues associated with FGM should be discussed. Above all, individuals should receive careful counselling. Where they are willing to resist community pressure in favour of FGM, such individuals should be given as much emotional and practical support as possible, including help in framing an argument most likely to resonate within their community.

Conclusion:

The success of attempts to end FGM will depend on wide-ranging campaigns in practising communities around the world. While the majority of cases of FGM occur outside Europe, migrant communities are important FGM-practising populations. FGM is upheld by social dynamics linked to the belief that members of a community expect the practice to be followed. Abandoning the practice is perceived as exposing daughters to social sanctions and marginalisation. However, where members of migrant communities are persuaded of the benefit of abandoning FGM, they can play an important part in changing attitudes in their country of origin. The key is to convey that abandoning FGM does not entail a loss of identity. For many, such a process is fraught with difficulty - the sense that rejecting tradition amounts to a betrayal of one's people, one's ancestors. FGM should be understood as a social norm: the abandonment of the practice is a choice influenced by complex relational, psychological, social and emotional factors. The battle for the abolition of FGM is definitely one that is too difficult to be left to individual crusaders and little old women. It has to be fought by all; particularly by government, health care professionals and other organisations.



TIMES OF MALTA - Sunday, July 27, 2014

Nurses appeal against bringing over of patients from Libya

Nurses have appealed to the government not to bring over patients from Libya who would eventually end up having no nurse or equipment for their care.

In a statement, the Malta Union of Midwives and Nurses said both the hospital's limitations and the shortage of human resources should be taken into consideration.

Bringing patients from Libya to Malta's 20-bed Intensive Therapeutic Unit, which was always full, was not the right decision.

According to international standards, there should be one nurse per patient at ITU. This was hardly adhered to normally as it was closer to three patients per nurse. Placing extra beds in ITU for the wounded in Libya would continue to have an impact on the nursing ratio. Patients from Libya would also have a direct impact on surgery, hospital acquired infections and bed availability.

"Our Nurses in ITU, our nurses in casualty, our nurses in Mater Dei are highly dedicated to their patients but none of them are superman/woman," the MUMN said.

Kelmtejn mis-Segretarju Ġenerali

Kif intom ħbieb? Nispera li kellkom iċ-ċans u l-opportunità sabiex tieħdu ftit mistrieħ mir-rutina tas-soltu. Wara kollox is-Sajf iġib miegħu din il-mentalità għalkemm naf ħafna nurses u li jippreferu jieħdu *break* sew fix-Xitwa. Mitt bniedem mitt fehma!

F'dawn it-tlett xhur kien hemm ftit movimenti fil-Union mhux ħażin. Lestejna l-preparamenti kollha sabiex f'Marzu li ġej inkunu nistgħu norganizzaw il-konferenza tal-*Commonwealth Nurses & Midwives Federation* għaliex issa reġa' jmiss lill-pajjiżna sabiex nilqgħu fostna lin-nurses u l-*midwives* barranin. F'dan il-ġurnal qegħdin nippublikaw il-poster ta' din il-konferenza fejn qed nitolbu lill-membri tagħna sabiex jissottomettu *abstract*. Din hija opportunità li m'għandhiex tintilef speċjalment għal dawk in-nurses u *midwives* li għadhom qatt ma ppreżentaw f'xi konferenza peress li din it-tip ta' konferenza isservi bħala *platform* fejn tista' tippreżenta l-*paper* tiegħek għall-ewwel darba u b'hekk takkwista l-esperjenza meħtieġa.

F'dawn l-aħħar ġranet bdejna nippreparaw għall-Elezzjoni sabiex jiġi elett Kunsill ġdid tal-MUMN 2015-2019. F'din l-elezzjoni ser ikun hemm tibdila sostanzjali peress li qed naġġornaw maż-żminijiet. Minflok li ser ikun hemm il-kaxxi tal-voti preżenti fl-isptarijiet u ċ-ċentri tas-saħħa, il-votazzjoni ser issir bil-posta f'*P.O. Box* apposta li tkun taħt ir-responsabbilità tal-Kummissjoni Elettorali tal-MUMN. B'hekk kulħadd fil-kumdità ta' daru jkun jista' jivvota u jimposta l-vot f'*self addressed envelope*. Aktar informazzjoni dettaljata tingħata fil-ġimgħat li ġejjien.

Din is-sena l-MUMN organizzat il-Jiem Internazzjonali tal-*Midwives* u n-Nurses b'mod differenti. Il-Kunsill tal-MUMN apprezza verament minn qalbu d-disponibilità ta' E.T. President ta' Malta Dr. Marie-Louise Coleiro Preca fejn litteralment fetħet il-bibien tal-Palazz ta' San Anton sabiex l-MUMN tikkomemora dawn iż-żewġ dati bi stil tassew opportun. Ġiet organizzata serata musico-letterarja għall-okkażjoni u riċeviment wara. Minn hawn nixtieq għal darba oħra nirringrazzja lill-President ta' Malta fejn ikkonfermat l-istedina għas-sena d-dieħla u estendiet l-istedina tagħha sabiex il-*Florence Nightingale Benevolent Fund* jorganizza l-attività tiegħu annwali fil-ġonna tal-Palazz fejn il-President ta' Malta hija l-Patrun ta' dan l-istess Fond.

Bħal ma tafu l-*Group Committies* tal-Union fuq il-post tax-xogħol huma attivi mmens. Hemm sodisfazzjon li l-membri qed tavviċinawhom u tkellmuhom fuq il-problemi li tiltaqgħu magħhom. Dan l-aspett għalina huwa importanti peress li l-kuntatt bejn il-membri u l-Union huwa ħaj u reali. Dawn il-*Group Committees* kontinwament jitolbu lill-Amministrazzjoni tal-MUMN sabiex ikunu aktar involuti fix-xogħol tal-Union għaliex iħossuhom kburin li jaraw li l-professjonisti li nirrapreżentaw ikomplu jimxu 'l quddiem.

Inselli ghalikom,

Colin Galea, Segretarju Ġenerali

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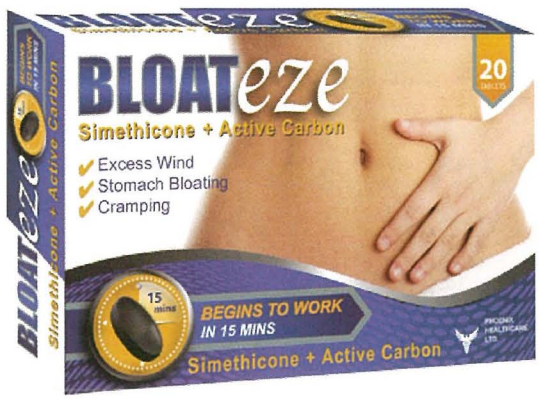

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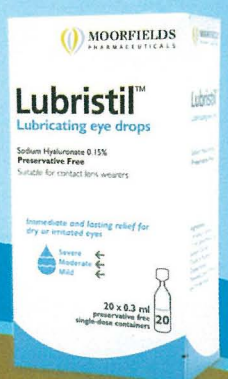

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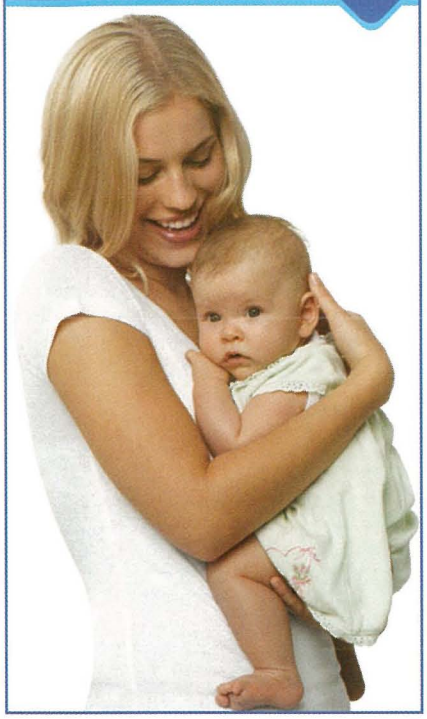

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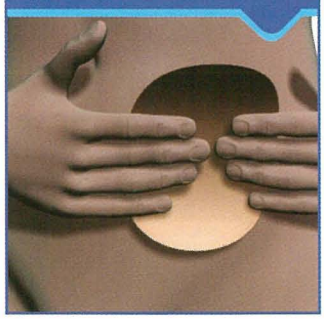
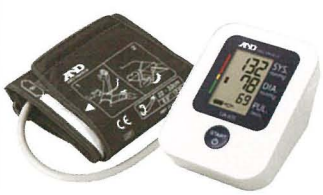


Blood Pressure



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Some aspects of care and case management

Care and Case Management can be provided by hospitals, rehabilitation facilities, out patients services and /or other community health agencies. No matter which/what organisation offers care and case management, it will only be successful if it concentrates on a well defined target group of patients for example people who are homebound, or persons who are older than 75 years old, or patients who have suffered from a stroke, or patients who are dying, or people needing to undergo renal dialysis, people with dementia or people with mental health issues, patients after spinal injuries or preventative care for teenage mothers and their babies.

Experience shows that fragmentation of care is quite a challenge with regards to care for complex cases within and across health and social care settings, especially in the community. In case management, the case manager does not look specifically at health issues or social matters, health diagnoses or the financial situation of the patient. The case manager's remit is to get a quick overview of all these matters with the help of the patient, family members/friends/neighbours and he or she will soon learn about the details as the process develops. Case managers link all available services in a professional manner. They need to have an understanding of the care needed and knowledge of the available providers and services in the system. The case manager would need to build up personal contact with the people of the patient's social network as well as with representatives and professionals of the various services.

How do clients/patients get into case management where it exists? In the literature, there is a clear distinction between whether accessing case management lies on the side of the client/patient or with the organisation/ case manager. All clients/patients introduced in the book Just in Case: Care and Case Management in Malta, were 'invited' into the case management process. Independently of the way of access, it is fundamental, that the client/patient freely agrees to becoming involved in the case management process. To find the correct scope and appropriate type of care, it is helpful to use tools that visualize and illustrate the situation. These maps help to give a quick overview, replace voluminous texts and identify multifaceted situations. Precise planning is important, especially because the case manager and the client need to identify the goals that she/he wants to achieve. Once this is done, the case management plan becomes a written document between the client/patient, the case manager and other persons/agencies involved. The arrangements of the plan are sealed and accountability is set up stating who is responsible for what.

Care and Case Management would need to work alongside other broad strategies of care.

Grace Jaccarini
Chairperson, MMDNA

Times of Malta
Friday, August 22, 2014

1,400 mothers benefit from new community post-natal care project

Some 1,400 mothers have, since April, benefited from a new community post-natal care project, the Parliamentary Secretary for Health, Chris Fearne, said today.

He said during a visit to a family that midwives had made 3,500 visits to over 1,400 mothers.

"Such midwifery services aim to bridge the gap between acute and community care and improve quality of care for post-natal mothers and their families", Dr Fearne said . He also reiterated the importance of ensuring the safety and wellbeing of both mother and baby.

Through this new service mothers are offered a detailed assessment identifying the mother's needs and her transition to parenthood.

Every mother receives three home visits, with the first visit carried out on the day after hospital discharge. During each visit the midwife assesses the mother and her baby, the home environment, provides advice on feeding and supports the mother in her transition to parenthood.

Dr Fearne urged all mothers and the public to participate in the upcoming Breastfeeding Policy consultation process. A meeting will be held next Friday at the Hotel Phoenicia at 9.30am. All those interested can get in touch with the Health Promotion Unit on 23266000.

Musbieh Editor's Note – One important aspect not mentioned by the Hon. Parliamentary Secretary is that this service was introduced due to hard work and initiative of MUMN to bid for an EU Project and eventually succeeded in obtaining the necessary funds so as the service could be delivered.

Death

an Augustinian approach

Death is horrible and destable. It shatters our human relationships. Death breeds loneliness. It fosters fear and sorrow. Death wounds us socially before it wounds us personally because it isolates us from those whom we have dearly loved and cared for. The terrible and agonizing feel of pain which accompanies death already shows how death takes up what it did not lay down and reaps what it did not sow (see Luke 19:22). Death's utmost insensibility is powerfully seen in the death of Jesus Christ, God Incarnate. Not even God managed to bypass it!

My pastoral practice at Mater Dei Hospital seeks to be strenghtened by various spiritual resources that are able to render it more effective, thus make it more pastoral. One of this resources is surely the eminent Western Church Father Saint Augustine, Bishop of Hippo. Although living in the fourth century the writings of this North African saint and Bishop are undoubtedly more relevant today then, perhaps were before. In many ways the human being has not changed. Not even in his fearful and somewhat supersititious ideas concerning death. Hence, the following thoughts which deal with Saint Augustine's idea of death are unquestionably realistic.

Death creates separation and sorrow. Everybody, including the believer, should cope with the pain of separation. Augustine indicates that even Saint Paul permitted grieving, save of course grieving like those without hope. In sermon 172 he writes: "Of necessity we must be sorrowful when those whom we love leave us in death. Although we know that they have not left us behind forever but only gone ahead of us, still when death seizes our loved ones, our loving hearts are saddened by death itself" (172, 1).

However the Christian believer needs not despair at the repulsive prospect of death. S/he should not let fear take him/her over. On the contrary, the reality of death can be lessened by the hope of what exits beyond death itself. Saint Augustine tells us that we should not be saddened by the death of a loved one. The Christian believer should realize that their loved one's death is like sowing the

seed that will certainly yield its fruit in eternal life at harvest time!

In sermon 361 Augustine encourages us: "Do not be sad! That which is buried in the furrow is no longer in the granary nor in your hands. But someday you will return to this field and you will be overwhelmed and delighted to see beauty where now you weep at the bareness of the plowed ground ... One by one through the years the harvests of earth are seen, while the harvest of humanity will finally take place at the end of the world"

For the Bishop of Hippo there are special situations wherein the believer may even wish death as a means to a better life and a mode of avoiding a painful life here without meaning of love. When faced with the eventual possibility of eternity the individual Christian should conscientously fear a "second death". Now this fear of choosing against God while still living in this world preserves the Christian from the calamitous option that is rendered irreversible by dying separated from God.

In the second chapter of "The City of God", the Bishop of Hippo show how horrific the second death actually is! "The death, then, of the soul takes place when God forsakes it, as the death of the body when the soul forsakes it. Therefore the death of both-that is, of the whole man-occurs when the soul, forsaken by God, forsakes the body. For, in this case, neither is God the life of the soul, nor the soul the life of the body. And this death of the whole man is followed by that which, on the authority of the divine oracles, we call the second death. And it is called the second death because it follows the first, which sunders the two cohering essences, whether these be God and the soul, or the soul and the body. Of the first and bodily death, then, we may say that to the good it is good, and evil to the evil. But, doubtless, the second, as it happens to none of the good, so it can be good for none".

Because it is natural that we, as human beings, feel the appalling pain of loss when a loved one passes away our sorrow should be eased by the hope we nurture that our loved one is actually enjoying the eternal share of the just. And we, as survivors, should let our belief in eternal life empower us that one day we shall be united together with all those who have left before us from this valley of tears. Moreover, as Saint Augustine rightly points out, the Christian faith furnishes us with the reality that Jesus Christ is with every human being, especially with those who are greatly afflicted by the dead of their loved ones. But Jesus does not live within a vacuum. He lives in the community of believers. Hence, the Church, acting in the name and the Spirit of Jesus, shares the journey of loneliness and sorrow undergone by those who mourn thanks to the caring love displayed by those good Christians who take seriously Christ's mandate of loving the needy ones. In a nutshell, we are closely related with the dead by means of our mutual caring concern for one another.

The real Christian should face his death with the utmost hope and humility. In "The City of God" Saint Augustine comments: "And hence we enjoy some gratification when our good friends die; for though their death leaves us in sorrow, we have the consolatory assurance that they are beyond the ills by which in this life even the best of men are broken down or corrupted, or are in danger of both results" (19, 8). Although our human weakness impedes us from reacting perfectly to death nevertheless God's grace assists us to face death. Since we are living in the here and now we need to live fully our life by increasing the life of God in us through serving and caring for others while joyfully praying to our God who is eager to respond to our prayers deep inside us.

When Rome fell and with it the destiny of western civilization started its decline Saint Augustine addressed the people of Hippo on their real destiny. "We who now believe and proclaim it by the words of the prophets and the preaching of Christ and the Apostle, we hope that we shall not fail, that we shall triumph over death, and not be burdened in heart with drunkeness and debauchery. But, girding our loins, with candles burning, we await with vigilance the coming of the Lord. Let us fast and pray, not because tomorrow we die, but so that we may die free from all care" (Sermo 361, 22, 21 (PL 39, 1611).

Is this Augustinian approach to death not the one espoused by every hospital chaplain, namely that through his sacramental presence each chaplain is a living witness that Jesus' life triumphs over death? That the grace of eternal life conquers the evil of death? That the best way to prepare for death and the most appropriate one to cope with it is vigilant prayer so that we are freed from any worldly ties that can obstruct our vision of the Heavenly Jerusalem?

Fr Mario Attard OFM Cap

How do we develop the modern nurse?

Much-publicised reforms to healthcare internationally mean nurses must now come armed with a much broader set of skills.

With people living longer thanks to technological advances and pioneering medical research, there is also an increase in the complexity of patient needs.

This puts nursing at the forefront of the changes to the industry and, with it, a greater demand for game-changing methods of developing the modern nurse.

The patient-focused care which is delivered by nurses worldwide remains pivotal in healthcare practice. However, the role of the nurse as care coordinator, and in managing complex healthcare needs, requires new developments in nurse education and practice.

Nursing has now become an all-graduate profession and nurses must become fit for practice, reflect on their own learning and become increasingly autonomous as they progress in their role as learner and subject and profession.

But how can today's nurses be made fit for the demands of healthcare in the 21st Century?

Online learning appears to be a genuine solution – and there are new courses popping up on the internet which can help provide training and development on an international scale.

Distance learning is a practical way for people to take their careers forward, by enabling them to step up to an honours degree while continuing to earn.

University of Derby Online Learning (UDOL) is one higher education provider which has responded to the challenge with its BSc (Hons) Nursing Studies (top up) programme, which it is delivering in partnership with Domain Academy – a higher education college which offers internationally-recognised diplomas and degrees in partnerships with various universities.

Studied totally online, it offers the opportunity for nursing students to continue learning, even after leaving (any) university with a diploma or advanced diploma. It is also suitable for those who wish to 'top up' their existing professional qualification and experience to a degree, without the need to leave clinical practice for a campus-based programme.

Study options focus on key areas for contemporary nursing, including leadership, asthma, diabetes, minor injuries, palliative care, dementia care and public health.

For more information on the course with UDOL – a leading UK University, please contact our local partners Domain Academy by sending them an email at info@domaingroup.com.mt or contact them on 21 433 688 or 27 433 688. They will guide you through the application process as well as provide you with all the necessary information and support.

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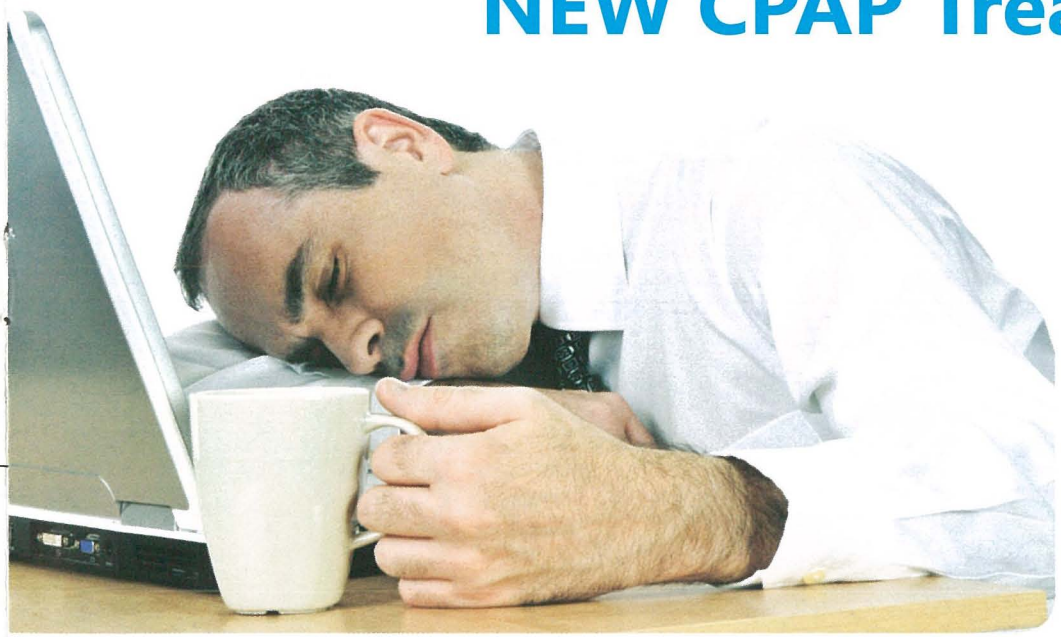

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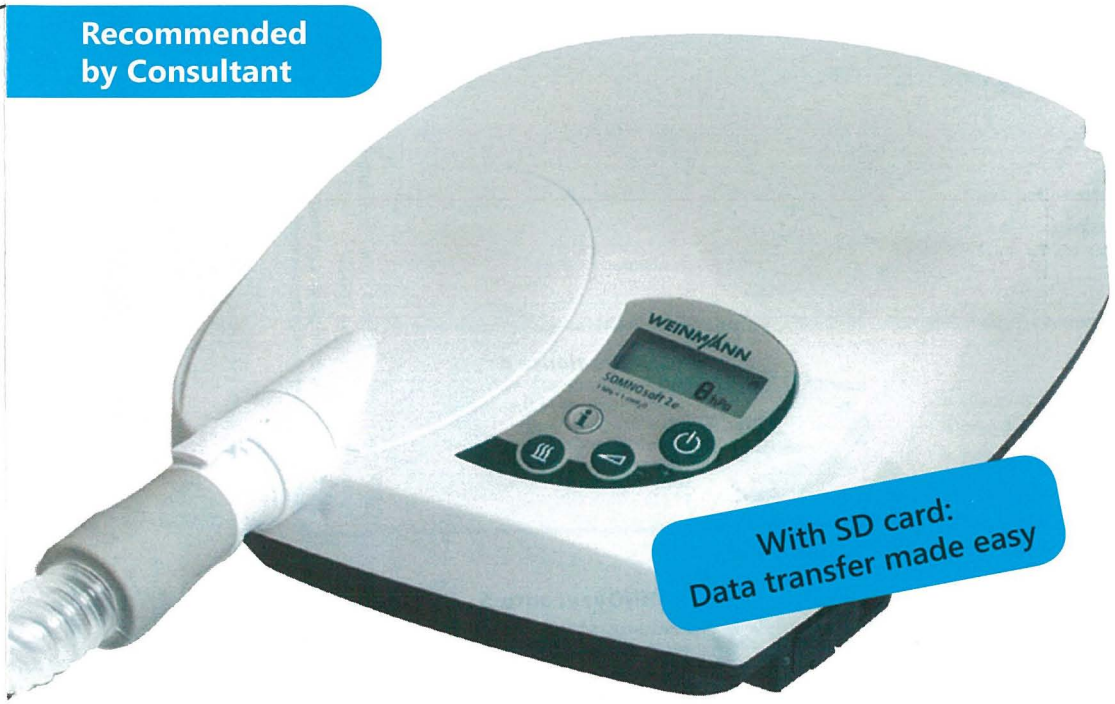

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from our diary...

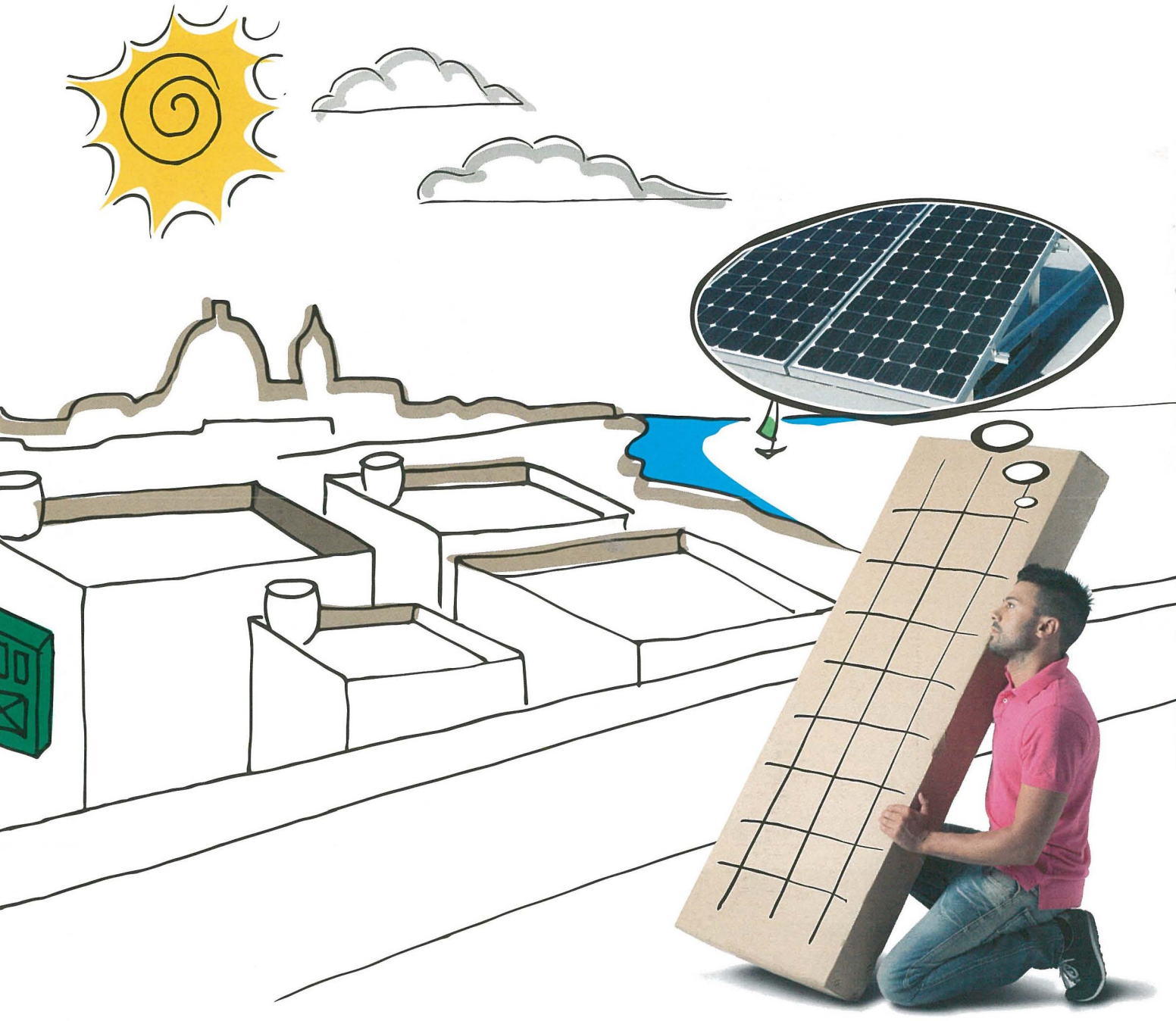
To celebrate the International Days of Midwives & Nurses, H.E. President of Malta Dr. Marie-Louise Coleiro Preca, accepted to organise these special commemorative days at the Presidential Palace at San Anton Gardens. It was really an unforgettable night for all those present. In these photos we can see the President of Malta and MUMN President addressing those present, the well established Tenor Mr. Joseph Aquilina giving his performance and MUMN Vice-President giving a donation to H.E. for the Community Chest Fund.

MUMN organised for the first time a Wellness Breakfast Seminar. From the positive feedback we received it is clear that it would not surely be the last time.

During the Wellness Breakfast Seminar a BOV representative attended and gave useful information to all those present.

Nurses working at the Admitting & Emergency Department assisting illegal immigrants on their arrival in Malta (photo from the Times of Malta).

A National Forum of Trade Unions had been set up with the initiative of H.E. President of Malta. A ceremony was organised on its launching at the Presidential Palace in Valletta.



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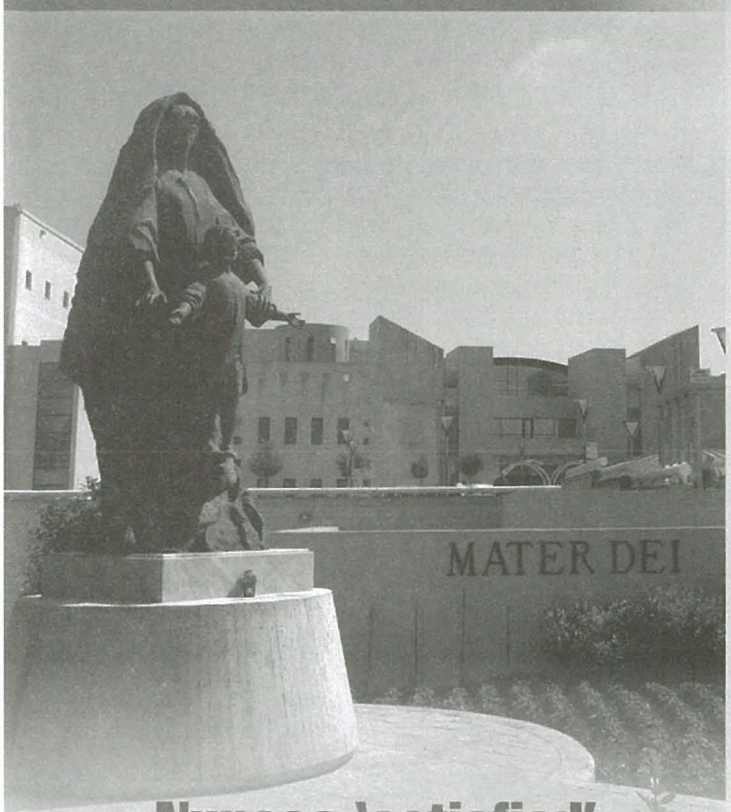
MALTATODAY
Staff Reporter - 3, September 2014



Nurses 'satisfied' with government's handling of weak hospital pillars

The Malta Union of Midwives and Nurses said that they are satisfied with the way the government has responded to the news that some pillars in the Accident and Emergency Department at Mater Dei hospital are too 'weak'.

"Health Minister Konrad Mizzi informed us that reinforcements to certain hospital pillars will have to be done immediately," the MUMN said. "Further tests will be done to test the concrete used in the foundation of the Accident and Emergency department.

"We also spoke about alternative sites for the new wards," the MUMN added.

A set of tests carried out on Mater Dei's Accident and Emergency department confirmed that the concrete used on certain pillars was of inferior quality. This means that they are not strong enough to withstand the weight of two planned medical wards.

The government announced in a statement that temporary works will be carried out this week to mitigate any risks that could arise from the weak pillars. The works will include setting up temporary structures to solidify the pillars.

TIMES OF MALTA - Saturday, July 5, 2014

Trapped nurses return home

Dozens of Indian nurses stranded in territory held by Islamic extremists in Iraq returned home to southern India today aboard a special flight, officials said.

The 46 nurses had been holed up for more than a week in Tikrit, where fighters of the Islamic State group have taken over. The nurses had been moved to a new area under the extremist group's control, and finally crossed over late Friday into Irbil, in Iraq's largely autonomous Kurdish region.

After a brief refuelling stop in Mumbai, the plane landed in Kochi, in Kerala state, where the nurses are from.

Akbaruddin tweeted that after dropping off the nurses, the plane would transport the others to the southern city of Hyderabad.

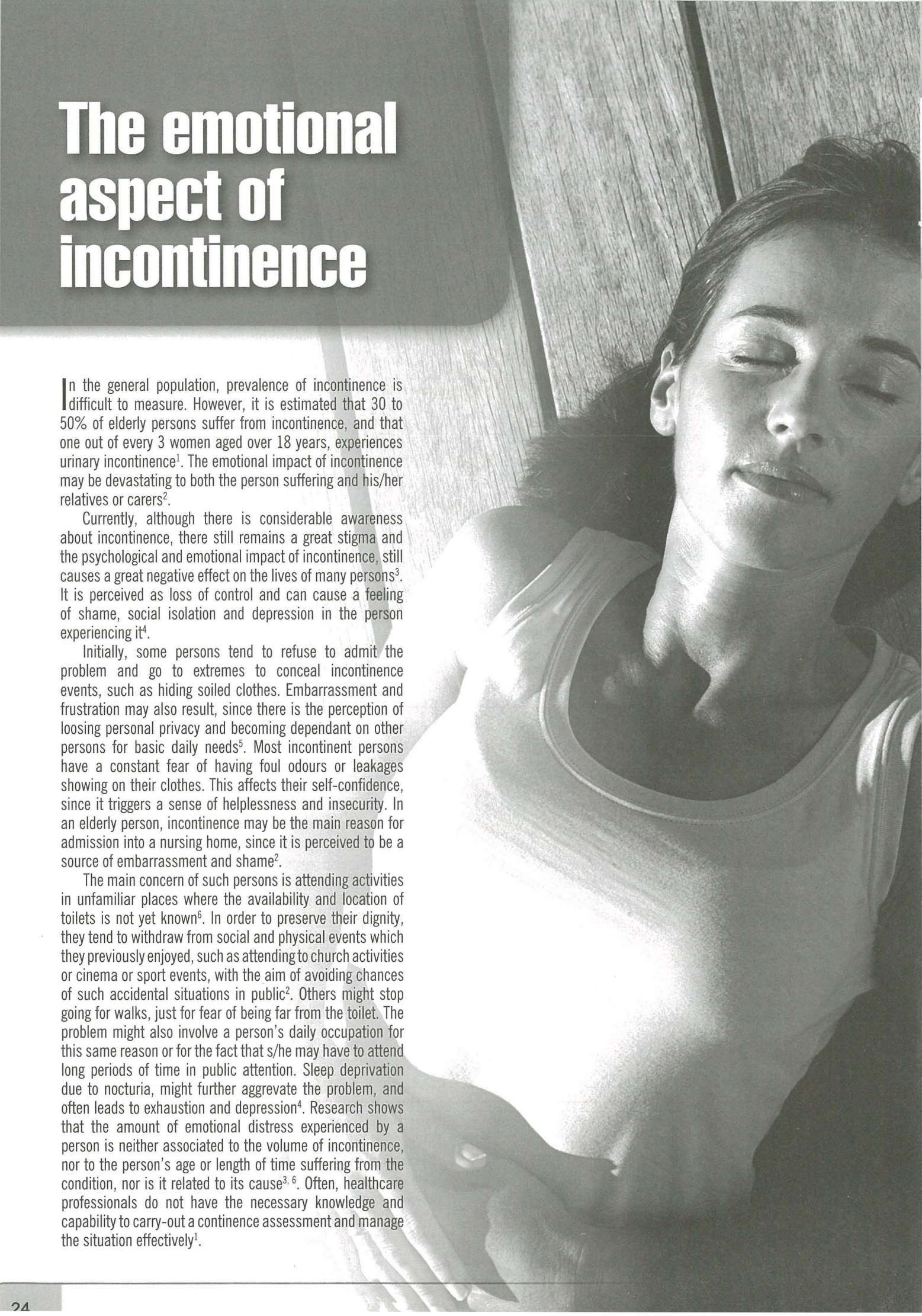
It remained unclear whether the nurses had been held by the militants or were just stranded in their territory. The Indian foreign ministry gave no details of how their freedom was secured.

According to the foreign ministry, 39 Indian construction workers abducted two weeks ago were still being held by the militants, but were safe and unharmed.

Speaking to reporters on Friday, Akbaruddin said that any details about the backroom diplomatic manoeuvres that India undertook to free the nurses would compromise the safety of the construction workers.

About 10,000 Indians work and live in Iraq, but only about 100 are in violent, insecure areas.

The emotional aspect of incontinence



In the general population, prevalence of incontinence is difficult to measure. However, it is estimated that 30 to 50% of elderly persons suffer from incontinence, and that one out of every 3 women aged over 18 years, experiences urinary incontinence[1]. The emotional impact of incontinence may be devastating to both the person suffering and his/her relatives or carers[2].

Currently, although there is considerable awareness about incontinence, there still remains a great stigma and the psychological and emotional impact of incontinence, still causes a great negative effect on the lives of many persons[3]. It is perceived as loss of control and can cause a feeling of shame, social isolation and depression in the person experiencing it[4].

Initially, some persons tend to refuse to admit the problem and go to extremes to conceal incontinence events, such as hiding soiled clothes. Embarrassment and frustration may also result, since there is the perception of loosing personal privacy and becoming dependant on other persons for basic daily needs[5]. Most incontinent persons have a constant fear of having foul odours or leakages showing on their clothes. This affects their self-confidence, since it triggers a sense of helplessness and insecurity. In an elderly person, incontinence may be the main reason for admission into a nursing home, since it is perceived to be a source of embarrassment and shame[2].

The main concern of such persons is attending activities in unfamiliar places where the availability and location of toilets is not yet known[6]. In order to preserve their dignity, they tend to withdraw from social and physical events which they previously enjoyed, such as attending to church activities or cinema or sport events, with the aim of avoiding chances of such accidental situations in public[2]. Others might stop going for walks, just for fear of being far from the toilet. The problem might also involve a person's daily occupation for this same reason or for the fact that s/he may have to attend long periods of time in public attention. Sleep deprivation due to nocturia, might further aggrevate the problem, and often leads to exhaustion and depression[4]. Research shows that the amount of emotional distress experienced by a person is neither associated to the volume of incontinence, nor to the person's age or length of time suffering from the condition, nor is it related to its cause[3, 6]. Often, healthcare professionals do not have the necessary knowledge and capability to carry-out a continence assessment and manage the situation effectively[1].

Healthcare policies promote the organisation of standard, integrated continence services which focus on the identification and assessment and appropriate care management of such patients[1]. A continence assessment should be done and management of incontinence should be according to its outcome. Besides individual diagnosis of the cause of incontinence, practitioners are advised to involve their patients in the treatment and care, and should consider individual requirements and preferences. Incontinent persons should be enabled to make informed decisions about their own care. Periodical reassessment ensures that the needs of such persons are being met in the best way possible[7]. This is very important because the continence needs of a person may change. In some cases the underlying cause may be diagnosed and treated and continence may be improved or even restored[1]. Similar situations occur in cases of recovery from illness such as heart attack, or flare-ups of arthritis or trauma involving bone fractures, where there is reduced mobility and bed bound situations for a limited amount of time. It is also important when the medical condition worsens and the patient's continence requirements increase.

Very often, incontinence is considered to be an aging problem which has to be accepted. Such attitudes lead to reactive care, as if the replacement of soiled clothes or diapers with clean ones is the only solution. Nurses are also encouraged to increase their knowledge in continence care, in order to be able to provide proactive care. Health-care organisations that focus on cost-cutting rather than exploring innovations in this area, create a barrier to the provision of optimum continence care. In England, due to the effect on the quality of life and the impact on the National Health Service resources, incontinence is a national healthcare issue, and nurses are expected to consider continence care as a fundamental aspect in nursing care[1].

Within the competing nursing demands, continence is often not considered as a high priority issue, and its emotional impact is frequently overlooked. Patient-centered care demands that practitioners should give more importance to the impact of incontinence on the well-being of a person in his/her daily activities. In the elderly, effective care and management may prevent early admission to long-term care facilities[1].

Policies and guidelines for Continence management strongly recommend the preservation of dignity and independence of such persons. Procurement of products used for incontinence should be according to the greatest value for meeting individual needs. Care teams working directly with such persons should be fully aware and understand the physical and emotional impact of incontinence in order to be able to give the right support and provide the best coping strategies[7].

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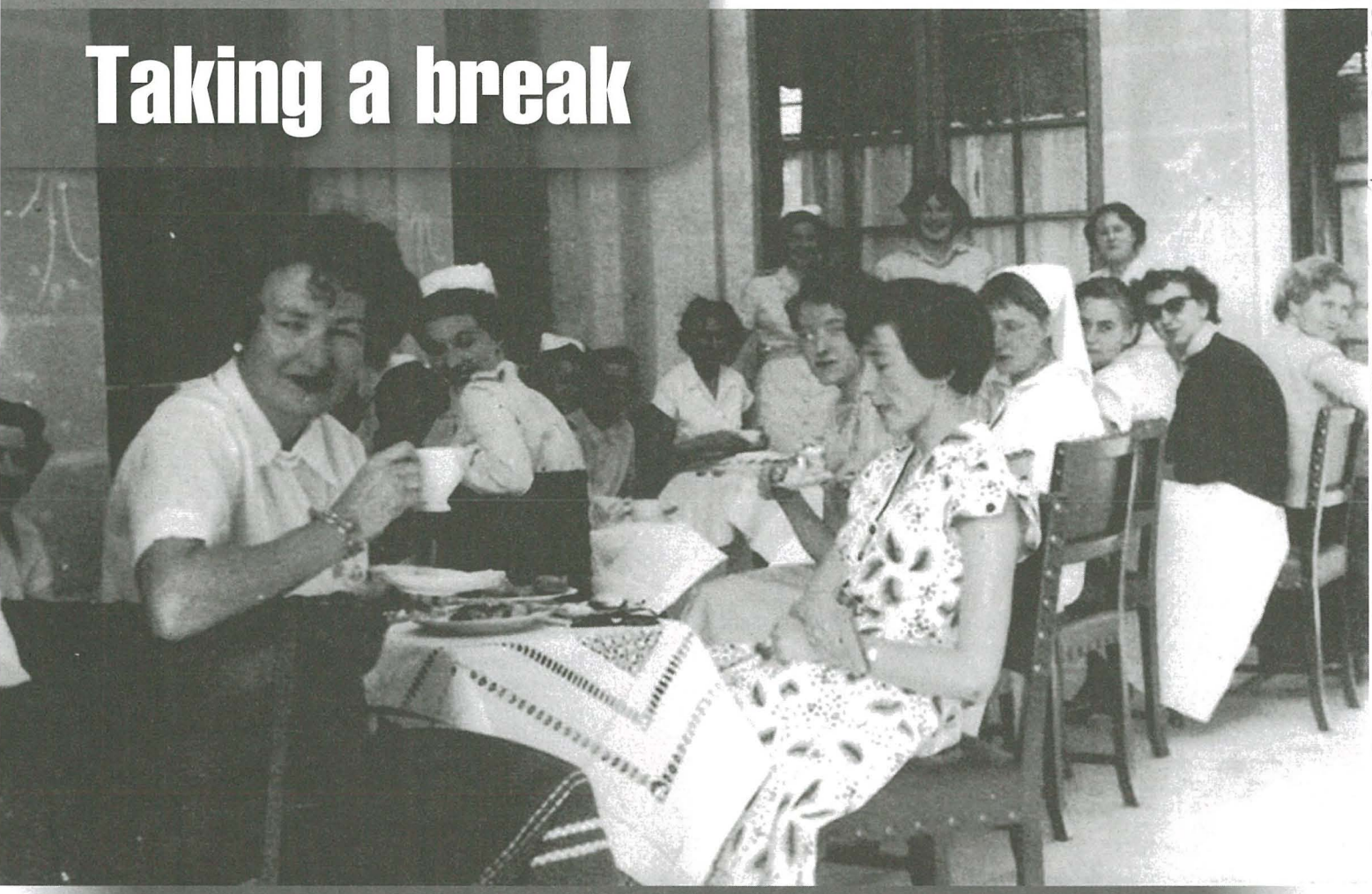
Tanya Carabott, P.Q.Dip.HSc (Mgmt)

Taking a break



Nurses and staff enjoy a teabreak at the David Bruce Royal Naval Hospital at Mtarfa in 1955. (Thanks to Isobel Lang for the picture)

TIMES OF MALTA - Sunday, July 27, 2014

SRNs recall good old student days

The SRNs held their much-awaited reunion in Valletta.

The Nursing School (Group 49) held a reunion to celebrate their 39th anniversary as SRNs. The event started off with Mass at Sarria church, Floriana, celebrated by Floriana parish priest Richard Borg.

The nurses remembered friends who were unable to join because of their work schedule or other domestic situations. They also remembered a special friend, the late Catherine Farrugia of Ðurrieq.

Over lunch in Valletta, the nurses recalled the good old days as students, how some of them got married and their family life.

Sr Frances Farrugia, OP, who has been serving the poor in Pakistan for the last two years, recounted her experiences and spoke about the different lifestyles in Malta and Pakistan.

Washing of weakened noses and treatment of allergic rhinitis

Allergic rhinitis is an international Public Health problem. In most western countries, it affects 10 to 25 % of the population and its prevalence is constantly increasing.
It is characterised by inflammation of the nasal mucosa and a group of symptoms (sneezing, obstruction and a watery nasal discharge) due to an excessive immunological reaction in the presence of an allergen. Owing to its impact on social life and productivity at work, allergic rhinitis gives rise to considerable indirect costs. Furthermore, following work by many researchers, the WHO considers it a major risk factor for asthma owing to the continuity between the nasosinusal and bronchial mucosae.
It is therefore necessary to treat allergic rhinitis by preventive and curative measures, among which washing the patients' noses occupies a paramount position.

Seasonal allergic rhinitis

Easily identifiable, since it occurs at the same period each year, "hay fever" is the result of an allergy to graminacea pollen. It appears almost everywhere in Europe from April to July and may be severely incapacitating in subjects who must preserve their alertness.

Perennial allergic rhinitis

It persists throughout the year and essentially results from contacts with various different allergens (dust and acarids, animal hair, moulds and occupational allergens). Family histories are often observed.

Whether seasonal or perennial, allergic rhinitis is considered severe if accompanied by at least one of the following symptoms: sleep disturbances and a reduction in social, sporting, professional or school activities.

In all cases, treatment combining preventive and curative measures must be instituted.

Prevention

As always in allergology, reducing the contact with the allergens is the first measure to be applied.
Washing the nose of the sensitised subject will make it possible to significantly reduce the quantity of allergens in contact with the nasal mucosa and the concentration of local inflammatory mediators.

Other hygiene measures will make it possible to eliminate or reduce the contact with the allergen in question: by using anti-acarid slip covers, by getting rid of pets, by airing living areas and by limiting cofactors that promote the allergy (passive smoking, solvents and other irritants).

Curative treatment

In order to reduce the allergy and its local consequences, one must resort to various combinations of a systemic treatment (essentially antihistamines, or indeed immunotherapy and corticosteroid treatment) and local treatments aimed above all at washing and decongesting the nasal mucosa, while reducing inflammatory phenomena.

WASHING THE NOSES OF SENSITISED SUBJECTS

During episodes of allergy, washing the nose with **STÉRIMAR® MANGANESE** as first-line treatment appears entirely appropriate, regardless of the origin and severity of the rhinitis.
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For both patients and professionals, the choice of **STÉRIMAR®** as prevention and **STÉRIMAR® MANGANESE** during allergic episodes comprises many advantages.
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Furthermore, **STÉRIMAR®** products contribute towards restoring the ciliary functions of the nasal mucosa. **STÉRIMAR® MANGANESE** therefore also improves nasal clearance, which allows better elimination of allergens and pollutants.

Furthermore, its anatomical nozzle allows completely safe use for the entire family.

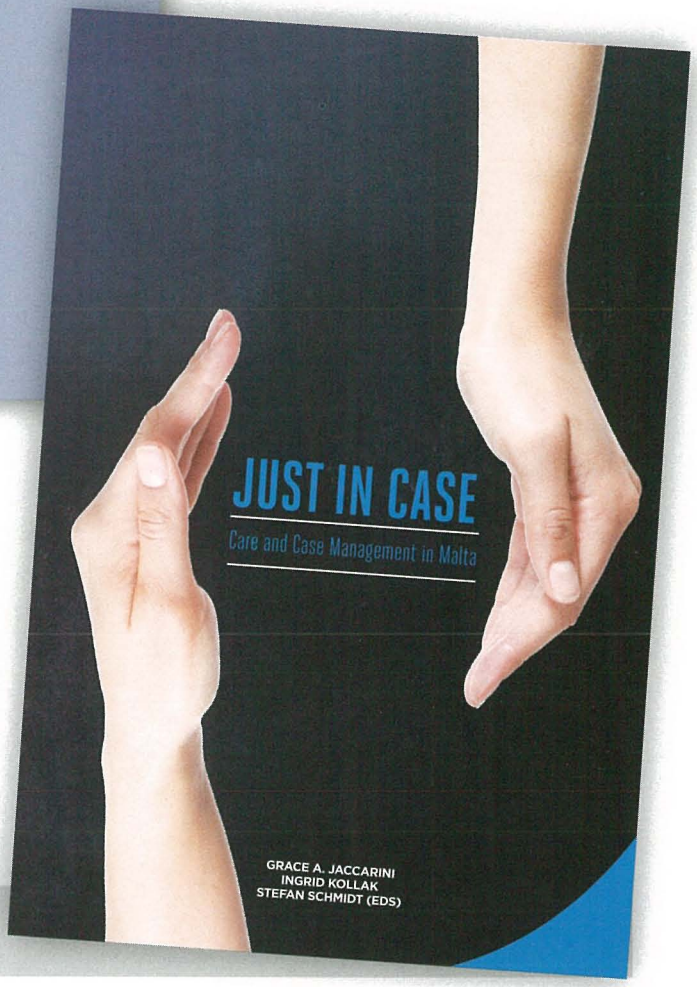
with the advice of Dr. Ph. Contencin, ENT

Just in Case

Care and Case Management in Malta

This book at a cost of 5 euros will become available later on this year. It is a 'must read' hand book for those who want to work together to provide better all round care for those individuals who need it. The methodology presented aims to inspire and enhance job satisfaction for those health care professionals, who understand the concepts and who will strive to work together in a collaborative way. Please send an email with your name, place of work and the number of copies required to Melita Farrugia at MMDNA to book your copy/ies, which will be delivered to you when it becomes available.

melitafarrugia@mmdna.com



JUST IN CASE

Care and Case Management in Malta

A must read for community and hospital nurses who wish to improve health care outcomes. This new textbook on Care and Case Management in Malta results from a collaboration of health care professionals and academics from Malta and Germany. The starting point was a workshop initiated and organised by Grace Jaccarini from Malta Memorial District Nursing Association (MMDNA), led by Ingrid Kollak and Stefan Schmidt from Alice Salomon University Berlin (ASH).

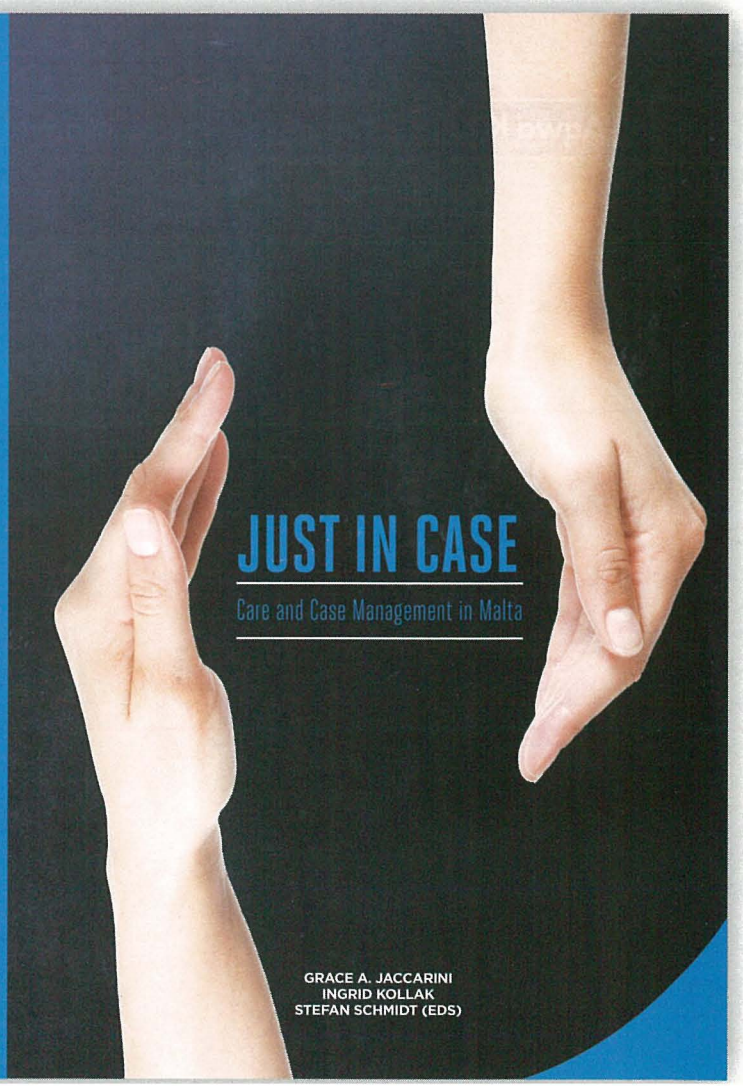
The essence of Care and Case Management is explained in an informed and coherent way through the application of a theoretical framework, which wraps the identification and the subsequent management of care needs, both anticipatory and actual, around the individual.

Case studies from practice are presented to demonstrate how this approach can be used to meet the needs of the most vulnerable as well as complex care needs existing in society.

An integrated care approach is recommended which suggests the need to develop a multi-professional approach as well as inter-professional learning to improve care delivery and outcomes.

DR MARK RAWLINGSON:
Pathway lead district nursing at University of Southampton and visiting examiner for community nursing, University of Malta 2014

JUST IN CASE



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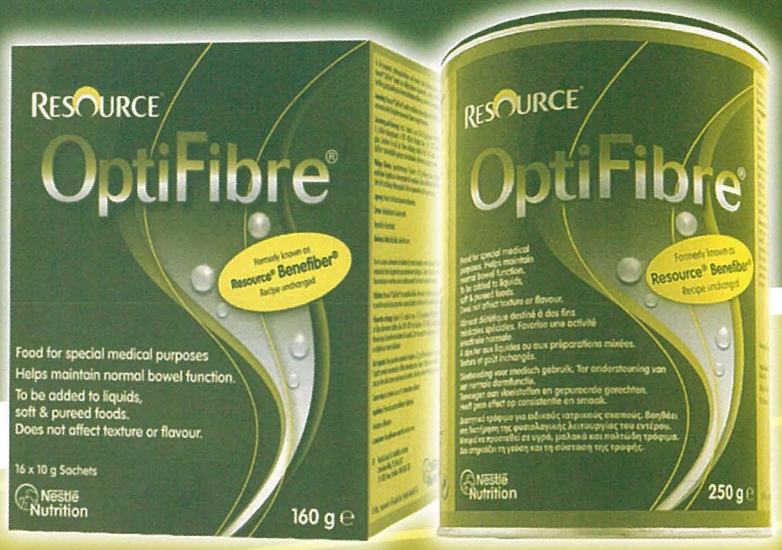

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Resource OptiFibre® is a soluble dietary fibre that helps maintain normal bowel function. The difference between insoluble and soluble fibre is that insoluble fibre is completely insoluble in water and minimally fermented in the colon, thus serving primarily as bulking agents; in contrast, soluble fibre dissolves in water and may be fermented by intestinal bacteria. Additional beneficial effects of fibre are associated with their fermentability. Partially hydrolysed guar gum (PHGG), the active component of Resource OptiFibre® is fermented by colonic bacteria liberating short chain fatty acids (SCFA's) which accelerate colonic absorption of salt and water. SCFA's are used as an energy source by the intestinal mucosa and are absorbed through the colonic wall, where they are metabolized to produce energy or transported into the general circulation. SCFA's also promote a healthy gut environment by stimulating the growth of beneficial bacteria such as bifidobacteria and lactobacilli, and inhibit the growth of harmful bacterial strains. Beneficial bacteria promote intestinal health by stimulating a positive immune response and out-competing the growth of harmful bacteria.

Resource OptiFibre® helps maintain normal bowel functions in patients suffering from constipation, diarrhoea and irritable bowel syndrome. Besides a regulatory effect on gastrointestinal function, Resource Optifibre® has shown positive effects on lipid metabolism and mineral absorption. The main clinical benefits of Resource Optifibre® are listed below:

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Prevents and treats acute diarrhoea.
Improves glucose and insulin response.
Helps in preventing hyperlipidemia.

Resource OptiFibre® has the advantage of improving patient compliance, given that it does not alter taste, texture or colour when added to food. Unlike other dietary fibres, Resource OptiFibre® mixes easily into hot and cold meals and beverages without impacting texture or flavour, thus assuring maximum acceptance by patients. Consequently, Resource OptiFibre® may be added to both hot and cold meals such as soups, pasta and other hot dishes or to liquids such as tea, coffee or juices. Resource OptiFibre® is non gelling, making the product also suitable for patients that use a PEG tube and require a fibre rich diet. This product may be recommended for both short and long term use.

Resource Optifibre® should be introduced gradually by simply adding 1 scoop (equivalent to 1/2 a sachet) to foods or liquids for the first 3 days. This dose may be gradually incremented by adding another scoop every 3 day interval until the desired effect is achieved. The maximum amount administered should not exceed 4 sachets/8 scoops per day.

Reference:

Slavin. J., N. A. Greenberg. (2003). Partially Hydrolyzed Guar Gum: Clinical Nutrition Uses.

MALTESE DELEGATES
3rd Horatio European Festival of Psychiatric Nursing – Malta
"Creativity in Care"
Intercontinental Hotel, Malta 6th-9th November 2014

Registration Details

The following fees are for Maltese delegates ONLY and cannot be used by any other country delegate. Festival fees include registration (either full or part) all festival materials, lunch on 6th/7th/8th, plus refreshments on all 4 days. It does not include travel, accommodation.

Please tick ✓ where appropriate:

Type of Registration	Full-time Student	Presenter	Early Bird Before August 31st	Standard From September 1st
Full festival				
MAPN Member	€180 ☐	€200 ☐	€220 ☐	€240 ☐
Non-Member	€200 ☐	€220 ☐	€240 ☐	€260 ☐
Daily rates – MAPN members				
Thurs 6th only	€60 ☐	€60 ☐	€70 ☐	€75 ☐
Fri 7th only	€50 ☐	€55 ☐	€60 ☐	€65 ☐
Sat 8th only	€60 ☐	€65 ☐	€70 ☐	€75 ☐
Sun 9th only	€30 ☐	€30 ☐	€35 ☐	€40 ☐
Daily rates – non members				
Thurs 6th only	€65 ☐	€70 ☐	€75 ☐	€80 ☐
Fri 7th only	€55 ☐	€60 ☐	€65 ☐	€70 ☐
Sat 8th only	€65 ☐	€70 ☐	€75 ☐	€80 ☐
Sun 9th only	€35 ☐	€35 ☐	€40 ☐	€45 ☐
Festival Party (8th)	€55 ☐	€55 ☐	€60 ☐	€60 ☐
Music night (7th)	Free	Free	Free	Free

All payments should be done in Euros. Cancellations received one full month before the Festival will be refunded minus a 25% administration fee. Regrettably, no refunds can be processed after this date. Programme may be subject to change.

Maltese Association of Psychiatric Nurses MAPN

HORATIO European Psychiatric Nurses

Registration – HORATIO Festival 2014

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Postcode

Telephone / Mobile

Email Address

Your Job Title

Name of Organisation

Special requirements (dietary, disability, etc)

MAPN Membership No (If Applicable)

Cheques should be made payable to:

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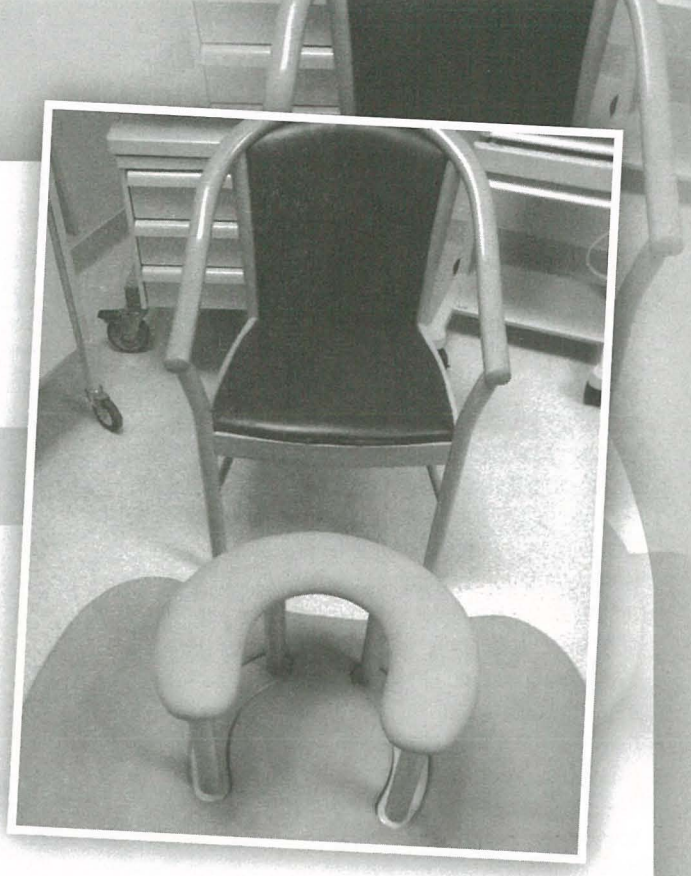


The freedom to move during labour

Article (2014) by Kylie Bezzina Bsc. (Hons) in Midwifery and Carmen Wareing S.R.N. & S.C.M.

Picture a woman in labour and what do you see? For most of us, the vision is instant: a bed, and a woman on her back. In fact, a recent survey showed that this vision represents reality: around 85% of UK women give birth on a bed. What's more, over half of women are delivering babies lying on their backs and over half of this group have their feet in stirrups too (Maternity Service Survey 2013)

The majority of women residing in countries where the western birth culture dominates give birth to their babies in semi-recumbent positions (sitting in bed). Since the 1970s, research has acknowledged the fact that upright birthing position (including on all fours, squatting, using birthing ball, chairs and stool) and mobility during labour enables the uterus to contract more efficiently, reduces perception of pain and shortens the second stage. As a result, women have a better urge to push, they require less interventions including the use of oxytocin for augmentation of labour, and therefore improved neonatal outcomes (Liu, 1974; Sleep et al., 1989).

Even though evidence shows that there are many advantages in the use of different positions that can be used during labour, still the bed remains the central piece of furniture in many of the birth rooms around the world. A bed is for getting into and it implies certain kinds of postures. In the majority of hospitals around the world, bed bound is perceived as normal, and sometimes even inevitable. Any change or variation to this type of setting where the bed is the centre of attraction, is perceived as innovative and daring (Jong et al., 1997). In fact, the idea of giving birth on a bed is so ingrained in our culture, that some of us just can not imagine doing so without one.

It is obvious that the birth environment has an impact; on how the women will progress throughout labour and on how the midwives will act and conduct the delivery (Shermer and Raines, 1997). A room that has the bed as the main focus with little supportive equipment and birth aids will not encourage a mother to change from the traditional use of the bed to mobilising and adopting different birthing positions (Chamberlain and Stewart, 1987).

NICE Guidelines (2007) recommend "women should be discouraged from lying supine or semi-supine in the second stage of labour and should be encouraged to adopt any other position that they find most comfortable"

Moreover, WHO (1996) advises against recumbent or supine position for longer periods during labour and birth and states that care givers should encourage and support the woman to take the position in which she feels most comfortable. Furthermore, it supports the fact that upright positions may improve childbirth outcomes and decrease the risk for instrumental deliveries.

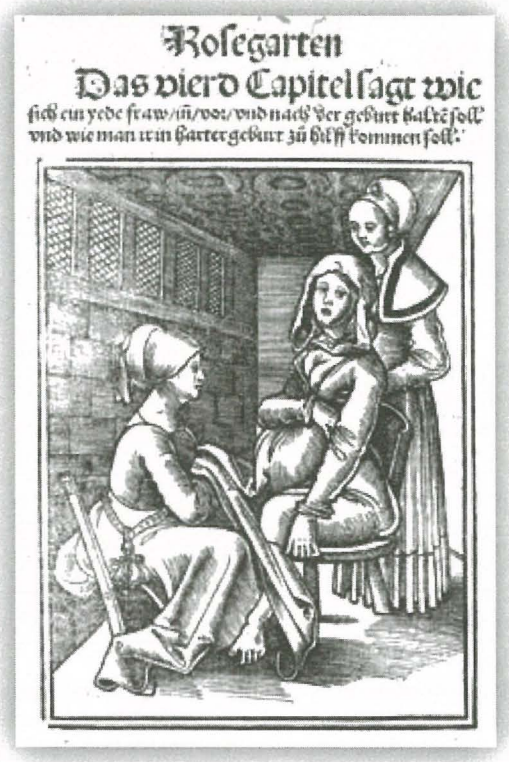
Recently our general state hospital has been provided with a birthing stool (picture 1) which has managed to transform many births into the most amazing experiences both for the midwives who chose to use it and for those mothers who believed that this non-traditional way will help them cope and feel empowered to deliver on the stool. Sitting and squatting is the most natural position for the woman. This birthing stool is specifically designed for use during childbirth in that it bears up a substantial amount of weight and pressure. Since it is low to the ground, the labouring woman can either relax her legs or plant them firmly to the ground. It allows a mother to sit or squat while giving birth, whilst at the same time she is able to lean back on her birthing partner for support. Most importantly, the birthing stool is designed like a horse shoe with a hole in the middle thus enabling the midwife to monitor the progress of labour whilst at the same time maintaining a hands off technique, and allowing a space for the baby to slide through.

Moreover, a labouring woman does not remain on the birthing stool for the duration of her labour, but she is encouraged to change position and move around. In the mean time the midwife, or the accompanying person, can perform some forms of complimentary therapy such as massage, aromatherapy, or even apply compresses to help ease the labour pain. These are done in conjunction with the breathing exercises. This combination will eventually result in less need for interventions and analgesia.

The concept of the birthing stool is ancient and has been widely practiced in many cultures. In fact, the birthing stool/ chair dates back to Babylonian times (2000 BC) and a famous drawing from Egypt depicts Cleopatra (69-30 BC) kneeling to give birth (picture 2). More recently, a French midwife, Louise Bourgeois (1563-1626) challenged the prevailing practice by shifting women from delivering on the bed to delivering on the chair (picture 3).

In 2007, a randomised controlled trial in Sweden, found that the birthing stool reduces the number of instrumental

vaginal deliveries, fewer reports of severe labour pain, fewer fetal heart rate abnormalities than supine posture, giving birth on the stool had no adverse consequences for perineal outcomes (ie, perineal lacerations, tearing or perineal oedema), and it was considered that it may even protect against episiotomies, however, more second degree tears were reported. The study, concluded that there was a higher incidence of blood loss, but only 500-1000ml which is considered physiological in a healthy population. The researchers however, noted that blood loss was increased regardless of birth position if women had been exposed to synthetic oxytocin augmentation during the first stage of labour. (Waldenstrgħm & Gottvall, 2007)



Women who gave birth on the stool reported a higher degree of satisfaction that they had made the decision themselves about their birthing positions and felt that they had been given the opportunity to take their preferred position. Women also reported that they felt more empowered, protected and self-confident, leading to greater childbirth satisfaction (Waldenstrgħm & Gottvall 2007). In 1991 a study conducted by the same authors (Waldenstrgħm & Gottvall, 1991) found that women who used the birthing stool seemed to have experienced less pain and expressed more satisfaction during their labour and delivery process

So, what began as a change in birth positions for the convenience of those assisting the mother in labour, has been shown scientifically to be an inconvenience for women and babies. Hence, providing women with the possibility of delivering on a birthing stool rather then instructing them to adopt the traditional position of going onto the bed, will make the woman feel more natural, supported and empowered throughout her birthing experience. The birthing stool offers an alternative mode to the traditional birth position. Women have the right to choose and to feel comfortable in whatever position they would like to deliver their baby.

Women experiences who delivered on the birthing stool since it was introduced few months ago at the General State Hospital

Mother 1: 22 year old woman who became mother for the first time using the birthing stool accompanied by her partner

"My experience of giving birth on the birthing stool is definitely a positive one. Prior to going into labour, I was carrying out my breathing exercises during the contractions and using the birthing ball at the Obstetric ward. Once my contractions intensified, I was transferred to the labour ward where I crawled up to the bed begging for an epidural. There was a change in shift and the midwife who was taking care of me introduced me to the birthing stool. The midwife showed me how to use the birthing stool and I was able to cope better with the pain and felt more in control of my body.

The stool also enabled my partner to stay behind me and massage my back to further ease the pain. The room had dimmed lights and music was playing in the background which also helped to make the atmosphere more peaceful and relaxing. In the meantime the midwife helped me to focus on my breathing exercises.

I gave birth to a healthy 3.19kg female and my perineum was intact. I encourage other fellow pregnant women to give this method a try. The fact that my partner was behind me massaging and supporting me, with the midwife alongside, guiding me through the process, made the whole experience easier and fulfilling for both of us. My partner and I went into labour with an open mind and open to suggestions from the midwives since they have the necessary knowledge and experience. We are glad we gave the birthing stool a try and without a doubt, if I'll be expecting another child the first thing I'll ask for when I'm in labour will be the stool."

Mother 2: 32 year old mother gave birth to her second baby on the birthing stool following a previous ventouse delivery

"In my first labour, I had quite a difficult time as my labour was induced and since it went on for what seemed like forever, I took all types of analgesia available. Due to the fact that I had an epidural, I was confined to bed and after an exhausting 2hrs of pushing, I had a ventouse delivery. This time round however, I was determined it was going to be different, and thank God my midwife encouraged me to remain mobile throughout all of the labour. She also introduced me to the birthing stool especially when it came to the second stage. The delivery was marvellous and both my partner and myself where overwhelmed by the experience. I delivered a 3Kg baby with a mere laceration to my perineum, and I needed no pain relief or medical intervention throughout. I have shared my wonderful and positive childbirth experience with all my friends"

Kylie Bezzina and Carmen Wareing: their experiences as midwives using the birthing stool:

Kylie Bezzina:- I always tried to aim to allow women to be mobile as much as they can during their labour and birth. Before the birthing stool was introduced into our practice I used to encourage women to deliver on all fours, squatting, standing or even kneeling. However, the birthing stool was something new and innovative and so I immediately started doing my research

and reading about its' risks and benefits. The birthing stool is another aid to help us promote mobility during labour and avoid the supine position. Since at the moment, only one birthing stool is available in our hospital, midwives should not forget that our beds can be turned into a "chair" like and women can still adopt the sitting position.

When we attended to the study programme in Bristol a lot of information was given to us regarding the different positions that can be used during labour and birth including the birthing stool. This filled me with so much excitement and motivation since it made me realise more than ever the importance of mobility during labour and how this can facilitate the process of birth while easing the pain. The advantages mobility has on the mother and her baby is so vast and evidenced based that we cannot oppose to those women who wish to stay mobile and use other positions rather than the supine one for their birth. With the support of my senior midwives I managed to help a woman deliver her baby on the birthing stool. It was such a wonderful experience, especially for the mother and her partner. For me the birthing stool gave birth and midwifery another whole dimension. Moreover, it continued to give me the drive to do further research so that I, together with my colleagues will be able to provide women with an unforgettable experience.

Carmen Wareing:- As a midwife with 22 years of experience, I have to admit that I was rather set in my ways and I have at times practiced midwifery following a certain routine. The birthing stool was introduced to my area of work just before I embarked on a normalising childbirth project to Bristol. This experience clearly motivated me to change certain aspects of my practice and the introduction of the birthing stool was the push I needed. To my amazement, I watched a newly graduate midwife conduct a stool delivery, and I was so impressed by the beauty of the whole experience, that I was determined to implement it as well. As a result, I have noticed that mothers cope much better in the 1st stage and they progress much better in the 2nd stage of labour. A hands off technique is also maintained, and with some dimming of the lights, and some relaxing music in the background, a beautiful birth setting is established. The birthing stool has proved to be a vital aid in midwifery practice since all parties are rewarded with better delivery outcomes and higher rates of satisfaction.

In conclusion we can state, that it is our role as midwives, to provide women with the necessary information on how they can mobilise and use different positions during labour. This should start from the antenatal period so that mothers who come to the labour ward would not have this imprinted image that they are going to deliver their baby on the bed like others do. Moreover, the use of the different positions and the birthing stool during labour should be supported by all the midwives working at the Obstetric wards and welcomed by the midwives working at the Delivery Suite. In this way we are creating a circle where women are constantly being made aware of the different aids being offered. This change involves many challenging factors however our mission should be aimed at providing women and their families with better opportunities and choices which will ultimately lead to better outcomes and higher satisfaction rates for all parties involved.

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FLORENCE NIGHTINGALE MUMN BENEVOLENT FUND
REVISON OF CURRENT BENEFITS

The Florence Nightingale Benevolent Fund (FNBF) aims at acting as a means of social support for its members who are passing through particularly difficult times. Benefits for members who have been contributing for at least six months include:

Claim submission

Claims are to be submitted to the FNBF Group Committee (GC) within twelve months from the date of occurrence. No funds will be given if the requested documents by the FNBF GC are not submitted.

Medical treatment abroad

Should a member require medical treatment abroad (which treatment is not available locally), an air ticket is offered to the member and another ticket to the person accompanying him/her. If the member's ticket is funded by the state, an air ticket is offered to the accompanying person only.

FNBF also offers €50, for each day spent abroad for treatment, up to a maximum of 28 days. These funds are allocated for the expenses of transport, food etc. during the stay abroad.

A married member's spouse and his children or legally adopted children or fostered children can also benefit from this clause. The provision for the children lasts until they arrive at the age of 18 years.

For a single status member who lives with his parents, his parents can benefit from this clause while the brothers and/or sisters can benefit until they arrive at the age of 18 years.

For a married member who lives with his spouse and his parents, his parents cannot benefit from this clause.

For members who are separated or divorced and their children live in a different address, their children can still benefit from this clause. When applying for this benefit a child birth certificate from the public registry has to be presented to the GC.

If a married member regains the single status and will start living with his parents, only his children will benefit from this clause. If the member does not have children or partner then his parents will benefit.

When a member lives with a registered partner, the partner can benefit from the fund but the partner's own children will not benefit. The partner will benefit after six months being registered with the GC.

The member is obliged to inform the fund for any changes in his status, and to send a copy of the partner's identity card to the fund.

Sick Leave

If a member is on sick leave half pay he/she may receive €232 every fortnight for a maximum of €464. The list of illnesses specified in PSMC Appendix 4.11 will only be utilized by the Group Committee when the amount of sick leave half pay is staggered.

If a member exhausts all his/her sick-leave entitlement on full and half pay and is on sick leave without pay, he/she may receive €464 every fortnight for a maximum of €1392.

Loss of allowances due to an injury on duty

If a member is not able to work due to an injury sustained while exercising his/her duties and, although receiving a basic salary, misses out on more than €230 in allowances, he/she will benefit from half of the allowances lost, up to a maximum of €700. It is important to note that funds will be given only to the injuries sustained during the full-time employment, and in the cases of part-timers, where this part-time employment is the only employment.

Financial support in conditions of terminal illness

If a member is diagnosed with a terminal illness, he/she has the right to apply to the FNBF GC, for a one time only, a maximum sum of €2000 to help in paying the treatment prescribed by the consultant doctor.

The member's beloved ones as listed in the benefit - Medical Treatment Abroad from point 3 to 9 – can also benefit for a one time only from 33% of their request to the maximum amount of €1000.

If the treatment is being paid by the Government, then the member or his/her beloved ones (applicants) has no right to apply. If the applicants opt to receive a different treatment, from that being offered by the Government and/ or seeks treatment abroad, the applicants must present a note from a local medical consultant stating the advantages

that the applicants would be receiving by taking a different treatment from that given by the Government and/or the advantages of receiving the treatment abroad. The FNBF GC has the right to seek a second opinion from an independent local medical consultant.

The member applying for this benefit can also apply for the benefits listed in the 'Medical Treatment Abroad', 'Sick Leave' and 'Counseling Services'.

If the FNBF GC receives other claims that are not attributed to terminal ilnesses but are as serious as these cases, they must refer them to the MUMN Council for its decision.

Retirement from work

Once a year a social function is organised in recognition of the service carried out by FNBF members who would have retired during the previous year. Each member is awarded a thanksgiving memento and invited to a reception. Members have to inform the GC that they are going to retire from work.

Counselling services

Members are entitled to individual/group counselling sessions with a professional counsellor from the Richmond Foundation. Where group sessions are concerned the GC may opt to refer the members to an alternative professional counsellor besides the Richmond Foundation. The GC is entitled to evaluate all requests related to group counselling.

Death of members

In the case of a death of a member, the sum of €1000 is given to the person who pays for the funeral as a contribution towards the funeral expenses.

Newsletters

Information about FNBF Benefits and activities organized by the GC are published in the MUMN Magazine 'Il-Musbieh' periodically.

Diary

Each year a diary is provided for free to all FNBF members.

Annual Meeting

Each year the FNBF GC shall organize a meeting to all the FNBF members. During this meeting the secretary of the GC reads out the administrative report while the treasurer will read out the financial report.

MUMN Council June 2014

Community Mental Health Day

1 in every 4 persons in the world will at some point in their lives go through episodes of mental health difficulties. Due to its high prevalence, every 10th October, the World Mental Health Day is commemorated with the aim of raising awareness of mental health issues as well as rallying for the support of mental health.

For this reason Community Mental Health Services shall be celebrating this significant cause by organising a one-time event. This event aims to:

promote awareness about the importance of mental health;

achieve equity for mental health care comparable to other health care services;

reduce stigma and discrimination against those with mental illnesses;

promote Community Mental Health Services;

raise funds to carry out activities throughout the year for service users

To achieve these aims, we are organising a variety of stands exhibiting information about our services and items produced during therapeutic activities by clients making use of our services. Additionally discussions shall be organised intermittently during the day. Healthy refreshments will also be available. Basic health checks shall be available during the event.

We would like to take this opportunity to invite you or representatives from your organisation to participate in this event. Furthermore we would greatly appreciate if you circulate this information across different channels of your organisation.

Practical details:
Date: Friday, 10th October 2014
Time: 9.00 - 15.00
Venue: Pjazza Robert Sammut, Floriana (in front of government pharmacy)
Tel No: 21220454/21220955

Please do not hesitate to contact us for further information about our services or the event

First announcement and call for abstracts

11th European Conference of the Commonwealth Nurses & Midwives Federation

Building Success - Nurses & Midwives Hold the Future

Friday - Saturday 6-7th March 2015

The organising committee invites abstract submissions from nurses and midwives, who are interested in sharing their skills and knowledge with a European audience.

CONFERENCE THEME

- Leadership • Evidence Based Nursing and Midwifery • Women's Health • Mental Health
- Innovations in Nursing and Midwifery Practice, Research, Education and Management
- Moving Nursing and Midwifery Forward • Practice Development Nursing and Midwifery
- Information Technology in Nursing and Midwifery
- Life Long Learning • Community Nursing and Midwifery

Abstracts should ideally fall within one of these categories, although other areas will be considered. However, presenters are reminded that papers need to include an indication of how their work addresses and adds value to nursing and midwifery.

GUIDELINES FOR PRESENTATION

To facilitate the selection and processing of abstracts, the following information needs to be compiled by the author. Please send to the conference organiser, through e-mail: **mumn@maltanet.net**

- Plenary sessions will be up to 30 minutes in length and include 5 minutes for questions
- Sessions normally run as one hour and may contain 2 to 3 papers
- Presentation sessions will be 20 minutes in length with 10 minutes for questions
- Posters should be visually stimulating and legibly presented
- Workshops are up to 2 hours in length

Please provide the following information:

1. Title (Dr / Mr / Ms) • 2. Name and Surname • 3. Job Title • 4. Qualifications • 5. Workplace • 6. Mailing address • 7. CYNMA, MUMN, RCN membership number • 8. Telephone number • 9. E-mail address • 10. Short Professional biography

Provide also the following on a separate sheet:

1. Title and theme of the paper • 2. Aim of the presentation • 3. At least 3 intended learning outcomes • 4. Prefer type of presentation (plenary, session, workshop, poster) • 5. Abstract of the presentation (not more than 300 words)

Please note: All participants chosen to present must register early for the conference to be eligible to present their papers. The conference committee regrets to inform you that is unable to meet any travel or subsistence expenses. The official conference language is English.

MUMN 1996

Royal College of Nursing

ΠΑ.ΣΥ.Ν.Μ ΣΥΝΔΕΣΜΟΣ ΝΟΣΗΛΕΥΤΩΝ ΜΑΙΩΝ ΚΥ.Ν.Μ.Α

Closing date for abstracts : Thursday 27th November 2014

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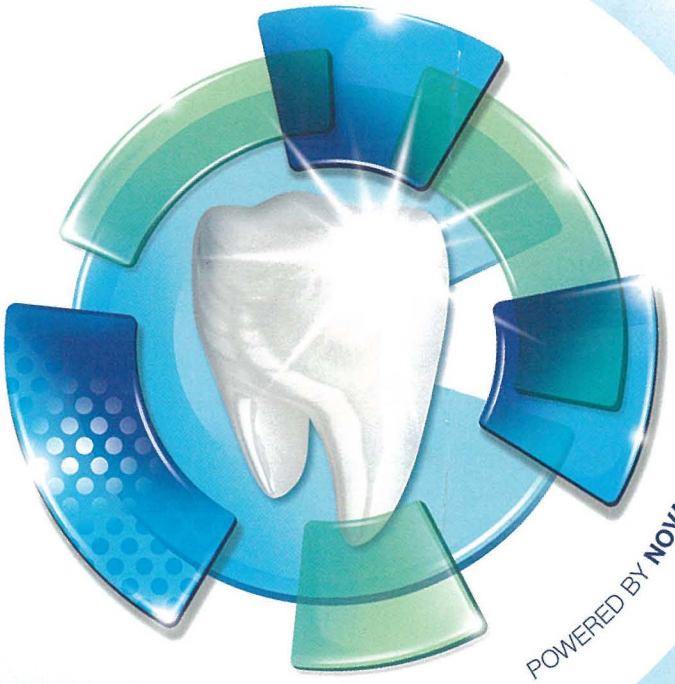

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